

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5199** STATE FILE NUMBER **63-022210**

|                     |              |
|---------------------|--------------|
| VS 300<br>Rev. 4/59 | DATE AMENDED |
| 1 <b>8420</b>       |              |
| 2 <b>8</b>          |              |
| 3                   |              |
| 4 <b>0</b>          |              |
| 5 <b>2</b>          |              |
| 6                   |              |
| 7 <b>1</b>          |              |
| 8 <b>2</b>          |              |
| 9                   |              |
| 10                  |              |
| 11                  |              |
| 12 <b>86-0</b>      |              |
| 13                  |              |

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

USE BLACK INK  
OR  
TYPEWRITER RIBBON

|   |  |  |   |
|---|--|--|---|
| 1. <del>Fall of 1963</del> <b>MAY 17 1963</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE <b>Texas</b> b. COUNTY <b>Cameron</b> admission)                                 |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br><b>St. Louis</b>   |  | c. CITY OR TOWN<br><b>Port Isabel</b>  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Masonic Home of Mo.</b>   |  | d. STREET ADDRESS<br><b>---</b>  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Lee A. Sears</b>   |  | 4. DATE OF DEATH<br>Month <b>May</b> Day <b>13</b> Year <b>1963</b>  |   |
| 5. SEX<br><b>M</b>  | 6. COLOR OR RACE<br><b>W</b>   | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>          | 8. DATE OF BIRTH<br><b>6/14/1876</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Refrigeration Engineer</b>  |  | 11. BIRTHPLACE (City and state or country)<br><b>La Bette County, Kan. U.S.A.</b>  |   |
| 13a. FATHER'S NAME<br><b>John T. Sears</b>  |  | 13b. MOTHER'S MAIDEN NAME<br><b>Pauline A. McLain</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>NO</b>  |  | 17. INFORMANT<br><b>Masonic Home of Mo. 5351 Delmar Blvd. <i>Lucas Robertson</i></b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b>                            |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>ONE WEEK</b>  |   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b>                          |  | <b>3 YEARS</b>   |   |
| DUE TO (c) <b>ARTERIOSCLEROSIS, GENERALIZED</b>   |  | <b>3 YEARS</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>FRACTURE, LEFT HIP 5 MONTHS</b> |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20a. ACCIDENT SUICIDE HOMICIDE<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)<br><b>420.0F</b>  |   |
| 20c. TIME OF INJURY<br>Hour <b>---</b> a.m. <b>---</b> p.m.   | 20d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>    | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   | 20f. CITY, TOWN, OR LOCATION<br><b>Carthage, Mo.</b>                                  |
| 21. I attended the deceased from <b>AUGUST 22, 1959</b> to <b>MAY 13, 1963</b> and last saw him alive on <b>MAY 13, 1963</b>  |  | 22. ADDRESS<br><b>5351 DELMAR, ST. LOUIS 12, MO.</b>   |   |
| 22a. SIGNATURE<br><b>Robert A. Hall, M.D.</b>   |  | 22c. DATE SIGNED<br><b>MAY 13, 1963</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   | 23b. DATE<br><b>5-14-63</b>  | 23c. NAME OF CEMETERY OR CREMATORY   | 23d. LOCATION (City, town, or county) (State)<br><b>Carthage, Mo.</b>                 |
| 24. FUNERAL DIRECTOR<br><b>Albert H. Hoppe Inc., 1700 Washington, Blvd.</b>   | 25. DATE RECD. BY LOCAL REG.<br><b>MAY 14 1963</b>   | 26. REGISTRAR'S SIGNATURE<br><b>Robert Smith, M.D.</b>   |   |

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed E. C. Conner + R. C. Rinehart

Licensed Embalmer No. 4283

P. O. Address St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.